

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-14-05.

The IRO reviewed therapeutic exercises, paraffin bath, neuromuscular re-education, analysis of clinical data, and office visits on 1-19-04 to 10-11-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO deemed the office visits on 1-29-04 and 5-21-04 were medically necessary in the amount of \$212.72. The IRO agreed with the previous adverse determination for all other services. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO Decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 2-17-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The requestor submitted a letter of withdrawal for dates of service 1-12-04 and 1-14-04 since the carrier paid all services except 99090.

Rule 134.202 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. Rule 134.202(e) states the payment policies regarding billing and modifiers. Rule 133.1(a)(3)(C) states that a complete medical bill includes correct billing codes from Commission fee guidelines in effect on the date of service.

The requestor billed code 99358-52 on 7-17-04 and 9-6-04. This modifier is invalid for this CPT code per Medicare; therefore these two dates of service will not be reviewed and no reimbursement can be recommended.

Code 99080-73 was billed for dates of service 1-23-04, 5-26-04, and 9-27-04 and was denied as "V - unnecessary medical"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The filing requirements have been met per the rule; therefore, recommend reimbursement of  $\$15.00 \times 3 = \$45.00$ .

Code 99080-73 billed for date of service 7-26-04 had no EOB submitted by either party. Per Rule 133.308(f)(3), the requestor did not submit convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, no review and no reimbursement will be made.

Code 97110 billed for dates of service 2-11-04, 3-22-04, 6-1-04 through 6-21-04, 7-13-04 through 7-29-04, 8-2-04 and 8-4-04 had no EOB submitted by either party. Per Rule 133.308(f)(3), the requestor did not submit convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, no review and no reimbursement will be made.

Code 99090 billed for dates of service 1-12-04 was denied as G – rebundled to a more comprehensive code that more accurately describes the entire procedure performed. Per Rule 133.304(c), the carrier did not state what the comprehensive code was. Therefore, this review will be made per Rule 134.202(b)&(c). Per Medicare, this code is a 'status B' and is adjunct to basic services rendered. Per Medicare, 99090 is not paid separately, but is bundled into payment for related services. Therefore, no reimbursement recommended.

Code 99090 billed for dates of service 1-12-04, 2-11-04, 3-22-04, 6-1-04 through 6-21-04, 7-13-04, 7-26-04, and 8-2-04, had no EOB submitted by either party. Per Rule 133.308(f)(3), the requestor did not submit convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, no review and no reimbursement will be made.

Code 97018 billed for dates of service 2-11-04 had no EOB submitted by either party. Per Rule 133.308(f)(3), the requestor did not submit convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, no review and no reimbursement will be made.

Code 97112 billed for dates of service 3-22-04, 6-1-04 through 6-25-04, 7-13-04 through 7-29-04, 8-2-04, 8-4-04, and 9-10-04 had no EOB submitted by either party. Per Rule 133.308(f)(3), the requestor did not submit convincing evidence of carrier receipt of request for reconsideration. Per Rule 133.308(g)(3), the carrier did not submit the missing EOBs as required. Therefore, no review and no reimbursement will be made.

Code 99455–VR billed for date of service 10–8–04 was denied as V, unnecessary treatment. CPT code 99455–VR is a TWCC required service and not subject to an IRO review; therefore the carrier denied inappropriately. The billing of code 99455–VR is in compliance with Rule 134.202(e)(6)(F); therefore, recommend reimbursement of \$50.00.

**ORDER**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees from 1–23–04 to 10–8–04 totaling \$307.72 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this 31st day of March 2005.

Medical Dispute Resolution Officer  
Medical Review Division

Enclosure: IRO Decision

March 25, 2005

TEXAS WORKERS COMP. COMMISSION  
AUSTIN, TX 78744–1609

CLAIMANT:  
EMPLOYEE:  
POLICY: M5–05–1440–01  
CLIENT TRACKING NUMBER: M5–05–1440–01/5278

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Workers Compensation Commission has assigned the above mentioned case to MRIOA for independent review in accordance with TWCC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the case in question to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the TWCC approved doctor list (ADL). The reviewer has signed a statement indicating they have no known conflicts of interest existing between themselves and the treating doctors/providers for the patient in question or any of the doctors/providers who reviewed the case prior to the referral to MRIOA for independent review.

**Records Received:**

Records from the State:

Notification of IRO assignment dated 2/17/05, 1 page

Letter from Texas Workers' Compensation Commission dated 2/17/05, 1 page

Medical dispute resolution request/response form, date stamped with several dates, 11 pages

TWCC-62 explanation of benefits for dates of service 1/19/04 through 10/11/04, 14 pages

Facsimile transmission form from Texas Workers' Compensation Commission dated 3/21/05, 1 page

Records from Requestor:

Medical dispute resolution request/response form, undated, 11 pages

Letter from Jupiter Health Works, Inc dated 1/5/05, 2 pages

Request for reconsideration dated 10/25/04, 2 pages

Request for reconsideration dated 10/25/04, 2 pages

TWCC-62 explanation of benefits for dates of service 1/19/04 through 9/10/04, 11 pages

Check list from Travelers Insurance dated 12/1/04, 1 page

HCFA forms for dates of service 11/7/03 through 10/11/04, 81 pages

Response to peer review reports dated 2/12/04, 4 pages total

SOAP notes dated 8/15/03 through 9/15/03, 23 pages

Texas Workers' Compensation work status reports/reports of medical evaluations dated 8/8/03 through 12/1/04, 37 pages

Rehabilitation program area of injury: hand/wrist reports dated 3/1/04 and 9/5/04, 3 pages

Subsequent medical reports dated 10/20/03 through 11/22/04, 14 pages  
Examination sheets dated 10/20/03 through 11/22/04, 13 pages  
Letters of causation dated 11/26/03, 3 pages total  
Medical review dated 2/3/04, 4 pages  
Orthopedic testing results dated 10/20/03, 2 pages  
Chart note dated 7/17/04, 1 page  
Initial medical report dated 8/8/03, 3 pages  
Reports of medical evaluation dated 3/18/04, 4 pages  
Follow-up reports dated 9/1/04 and 10/27/04, 2 pages  
Initial evaluation dated 7/14/04, 7 pages  
Return to work/school report dated 5/21/04, 1 page  
Office notes dated 3/11/03, 6 pages  
MRI report dated 8/22/03, 1 page  
Nerve condition studies report dated 9/5/03, 2 pages  
Reevaluation dated 7/14/04, 1 page  
New patient evaluation dated 6/4/04, 2 pages  
MD recommendation for upper extremity EMG/NCV form dated 7/14/04, 1 page  
Letter from Dr. Oishi dated 7/14/04, 1 page  
Electrodiagnostic results report dated 7/27/04, 5 pages  
Letter from Texas Workers' Compensation Commission dated 1/9/04, 1 page  
Verification for letters being sent, undated, 1 page  
Decision and order dated, received date 1/7/04, 3 pages  
Notice appeal filing date, undated, 1 page

**Summary of Treatment/Case History:**

The patient is a 40 year old female with a work-related injury to her right wrist and forearm suffered as a result of repetitive motion on \_\_\_\_\_. She carries a working diagnosis of right upper extremity carpal tunnel syndrome, right upper extremity neuritis, C7-T1 radiculopathy, and tenosynovitis of the right hand and wrist. An MRI of the right wrist without contrast enhancement on 8-22-03 revealed nonspecific "crowding" of the tendons within the carpal tunnel that may be associated with carpal tunnel syndrome, clinical correlation was suggested. Upper extremity NCV studies and upper extremity somatosensory/dermatomal evoked potentials were performed on 9-5-03; findings were unremarkable, but the interpretation was read as EMG evidence of right C7-T1 radiculopathy. EMG/NCS 7-27-04 showed an abnormal EMG insertional pattern, decreased recruitment in the bilateral upper extremity C8-T1 innervated muscles. The patient has been off work well over a year due to this injury. She has mainly been treated with therapy and physical modalities to the right upper extremity

and pain medication. Surgery was mentioned as a possible remedy. The patient underwent a Report of Medical evaluation on 3-18-04 by Douglas M. Wood, D.O., in which he placed her at MMI as of 3-18-04 with a WP IR of 8%. The treating doctor, Tim E. Peele, DC. disagreed with both the certification of MMI and the IR.

#### **Questions for Review:**

The dates of service in dispute include 1-19-04 through 10-11-04. The items in dispute include #97110/therapeutic exercises; #97018/parrifin bath; #97112/neuromuscular reeducation, #99090/analysis of clinical data; and #99214/office visits. Denied by carrier for peer review with "V" codes.

#### **Explanation of Findings:**

The following active and passive therapeutic procedures are not medically necessary: #97110/therapeutic exercises, #97018/parrifin bath, and #97112/neuromuscular reeducation. According to the medical records, there is no convincing evidence that this patient has carpal tunnel syndrome. The patient has signs and symptoms consistent with a sprain/strain of the right wrist, elbow. An MRI of the right wrist on 8-22-03 showed only non-specific "crowding" of the tendons within the carpal tunnel, a finding that is not diagnostic for carpal tunnel syndrome. Upper extremity nerve conduction studies and upper extremity evoked potentials performed on 9-5-03 revealed findings of decreased recruitment in the right extensor digitorum communis muscle (C7-C8), right abductor pollicis brevis and abductor digiti minimi (C8-T1) muscles. The study was interpreted as a right C7-T1 radiculopathy. The findings of this study do not meet the criteria for a diagnosis of a radiculopathy. EMG needle studies of the cervical and thoracic paraspinals must be performed as well, in order to make the diagnosis of a radiculopathy. Somatosensory evoked potentials were normal in this study. Therefore, a diagnosis of carpal tunnel syndrome or radiculopathy cannot be made. In regards to the EMG/NCS of the bilateral upper extremities performed on 7-27-04, this test also did not test the cervical and thoracic paraspinal musculature, and therefore cervical/thoracic radiculopathy cannot be definitively diagnosed. NCS did not show any evidence of carpal tunnel syndrome on the right. There was not a statistically significant difference in the median motor nerve conduction velocities above and below the right wrist. Median motor amplitudes were unremarkable above and below the right wrist. Decreased nerve conduction velocities and amplitudes traveling across the wrist are indicative of median nerve entrapment. Peak sensory latencies of the bilateral median, ulnar and radial sensory nerves were not increased across the wrist either on the right or the left, a finding suggestive of no neuropathy involving any nerve in either extremity. In nerve entrapment, such as in the case of carpal tunnel syndrome, the smaller more sensitive sensory nerves in general would be effected much earlier than their larger, motor counterparts. The sensory portion of an EMG/NCS is usually the first portion of this study to become abnormal in cases of nerve entrapment. As to the patient's other diagnosis of

median and ulnar nerve neuritis and tenosynovitis of the wrist, there is no supportive, definite objective or subjective evidence in support of these diagnoses. The patient's complaints are vague and non-specific. The patient's recent history of pregnancy could present as a transient carpal tunnel-like syndrome with symptoms usually resolving postpartum. In any event, conservative management with physical therapy, wrist brace, and NSAIDs should improve the patient's symptoms within the first 12 weeks after treatment is started with a return to work if she is not a surgical candidate (as in this case).

Therefore, any active or passive therapy past 12 weeks after the reported symptoms is not medically necessary.

As to the medical necessity of CPT code #99090/analysis of information data stored in computers (e.g., ECG's, blood pressures, hematologic data), this too is not medically necessary during the dates in question from 1-19-04 through 10-11-04 for the same reasons as stated above, that the patient's symptoms should have improved long before these dates of service and any data analysis is not necessary beyond that time.

As to the medical necessity of CPT code #99214/office visit, a follow-up every 3-6 months would be appropriate in this case due to the lack of objective and subjective evidence of the patient's current, working diagnosis. As mentioned above, this patient has signs and symptoms more consistent with right wrist and elbow sprain/stain. CPT code #99214 was used once for date of service of 1-29-04. This office visit would be considered medically necessary. CPT code #99214 was also billed on 5-21-04. This was within the range of 3-6 months. This visit was medically appropriate for the frequency of visits for an established patient. Therefore, CPT code #99214 for date of service 5-21-04 was medically appropriate and necessary.

**Conclusion/Partial Decision to Certify:**

As stated above, the only medically necessary CPT code was #99214/OV for dates of service 1-29-04 and 5-21-04. CPT code #99214 for dates of service 1-29-04 and 5/21/04 are certified as medically appropriate and necessary for an established patient.

The following CPT codes/procedures for the dates of service 1-19-04 through 10-11-04 are not certified as medically appropriate and necessary:

#97110/therapeutic procedures (decision to not certify)

#97018/application of a modality to one or more areas; paraffin bath (decision to not certify)

#97112/therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement (decision to not certify)

#99090/analysis of information data stored in computers (e.g., ECGs, blood pressures, hematologic data) – (decision to not certify)

**Applicable Clinical of Scientific Criteria or Guidelines Applied in Arriving at Decision:**

The medical records submitted; MRI of the right wrist without contrast enhancement 8-22-03; EMG/NCS of the upper extremities 9-5-03 and 7-27-04; The medical literature.

**References Used in Support of Decision:**

Physical Medicine and Rehabilitation, Second Edition, 2000, Richard L. Braddom, M.D.; Practical Manual of Physical Medicine and Rehabilitation, Diagnostics, Therapeutics, and Basic Problems, 1998, Jackson C. Tan, M.D., Ph.D., P.T.

The physician providing this review is board certified in Physical Medicine & Rehabilitation. The reviewer holds additional certification in Pain Management. The reviewer is also a member of the Physiatric Association of Spine, Sports and Occupational Rehabilitation. The reviewer is active in research and publishing within their field of specialty. The reviewer currently directs a Rehabilitation clinic.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

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